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Social and psychological gerontology

Quality of institutional life

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Introduction

During the past three or four decades, concern over the quality of life of old people living in a variety of nondomestic settings has been a key feature of research in social gerontology. Indeed any discussion of the definition of quality of life as it relates to successful aging finds that much of the literature is concerned with life within institutional environments rather than domestic ones.¹ In many studies, quality of life has been used as a measure of the outcome of interventions. In the main, researchers working within institutions have not been concerned with the (quality of the) lives of individual people, but with a collective response – often couched in terms of satisfaction or well-being – to living in a particular environment.

There is often some confusion between the use of the term 'quality of life' and 'quality of care', the latter relating to part of the process of institutional living. This distinction, between the lives

of individuals and the outcome of a particular type of intervention, is crucial to our understanding of the concept of quality of life as it has evolved within gerontology. The theoretical underpinning of such work is commonly couched in work on institutions and the interactions between person and environment, rather than particular philosophical debates.²

In recent years we have seen the diversification of residential provision, the development of regulatory frameworks and the monitoring of institutional settings. The terms 'quality control' and 'quality assurance' have now become commonplace. The rhetoric surrounding the importance of hearing the voice of the user has grown and we have witnessed the change from respondent or passive recipient to consumer to user. This change in semantics has been paralleled by real changes to active participation in some areas, but finding ways of including the voice of the user as a real measure of outcome remains a vital goal in true quality-of-life research.

These changes are indicative of a re-assessment of the research effort concerning the quality of life for older people within institutional settings. Following the publication in 1988 of the Wagner

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report, which reviewed the field of residential care,³ there has been a move towards more generic research – across settings rather than related to particular client groupings.⁴ There is also more concern to try to act on the body of research findings. Putting policy into practice has become more of a reality.

This article is concerned with all these issues: first, the frameworks for quality-of-life research, the methodologies used and the research findings; and then the move from this more traditional type of academic research to developments in quality control and quality assurance, noting how the one has developed from the other and the consequences for methodological innovation.

Theoretical perspectives underpinning the quality of institutional life

A review of the literature shows that two areas have been most influential. First, that concerning the theory of institutions and organizations,⁵ and, second, models of congruence between person and environment.^{6,7} Much of the research in these areas has come from the USA, where a number of complementary themes have emerged from the disciplines of psychology and sociology, converging in what can be described as interactionist, transactional, and ecological perspectives.⁸ One of the important features of this work has been the development of scales and schedules for measuring aspects of the institutional environment and the well-being of older people.⁹ This body of knowledge has been adapted and extended by researchers in other countries.^{10,11}

In the UK the influence of Goffman's work on 'total institutions' cannot be overstated. In *Asylums*, Goffman focuses on the similarities between institutions rather than their differences, and presents an abstracted ideal of 'institutional totality' against which reality can be measured.¹² In doing so he identified four main characteristics: the rigidity of routine; the block treatment of inmates; the depersonalization of inmates; and the social distance between staff and inmates.¹³ As a consequence, much of the work in long-term care settings for a range of client groups has centred on understanding and measuring the social/organizational environment; in particular,

the regime which pervades the institution. The influence of the physical environment and the characteristics and experiences of residents and staff – over and above their contribution to the social environment, has remained secondary until more recently. Models of care have subsequently emerged ranging from those which at their worst offer containment (warehousing model) or, at best, enhance the lives of residents (horticultural model).¹⁴

While long-term care settings for older people have been equated with the characteristics of 'total institutions', a counter trend has also been seen in the move to introduce the principles of 'normalization' based on humanitarian ideals about the value of individuals.¹⁵ This trend is also reflected in the work of Willcocks *et al.*, the first researchers in the UK to consider the ordinary domestic setting as an alternative starting point for assessing residential care for older people.¹⁶ In looking first at the concept of home for older people and its meaning, they sought to highlight the differences between domestic and residential settings and the adjustments which can or cannot be made to institutional life. In contrast, others have pointed to the need to recognize utilitarian ethics within long-term care where enabling 'the greatest good for the greatest number' is stressed.¹⁷

Evaluative frameworks for research

Theoretical developments have been paralleled by advances in methodology. Whilst it is true that much early research was descriptive, seeking to reveal the poor circumstances in which older people lived,^{18,19} later work developed more sophisticated evaluative frameworks.^{20,21} In particular, researchers have been influenced by the models of evaluation proposed by Donabedian²² within health care settings and Davies and Knapp²³ within social welfare. Donabedian is concerned with an assessment of the quality of care by considering:

structure — process — outcome

By structure he means the characteristics of those who provide care and the resources with which they have to operate: physical, financial, social. Such a structure underpins the relation-

ship between the providers and receivers of care, which is the process to be studied. By studying the structure and the process, we should therefore be able to say something about the outcomes. Outcomes include changes in the person's current and future state of health which are due to the care received, and 'may include social, psychological, and physiological functioning, as well as attitudes, including satisfaction'.²⁰ Survival rates are also commonly used as a measure of outcome within health care settings.

Donabedian's work has much in common with the model proposed by Davies and Knapp. In utilizing the language of production relations, they outline the following sequence:

inputs — intermediate outputs — final outputs

Here inputs are used to describe resources and all other factors which contribute to quality of care, while outputs are split between those which are related directly to the quality of care (intermediate) and those which are of a higher order and relate to quality of life (final).

Within these frameworks lie definitions of both output and outcome, which in long-term care settings for older people become difficult to disentangle. Outputs traditionally relate to productivity based on the 'aims' of the organization, while outcome measures the achievement of intended results. A number of authors have commented on the ill-defined nature of long-term care for older people, particularly residential care.^{23,24} The diversification of care providers during the 1980s, debates about nursing and personal care, and changing attitudes to forms of accommodation plus care in later life all add to the confusion over the function of different types of setting. For these reasons an understanding of outcomes/outputs based on measures of psychological well-being or life satisfaction have to be set within the context of the current climate of opinion as to what the setting is trying to achieve.

The difficulty is apparent in the problems associated with utilizing indicators of quality of life developed for populations in the community. In the late 1960s, 1970s and early 1980s, those involved in developing social indicators, predominantly from the USA, focused attention on measures of well-being and quality of life as a means of understanding global, national and local patterns of diversity and inequality.²⁵ On

the whole, the concerns of this movement had not been with understanding outcome for those in receipt of services or with evaluative research in institutional settings, and yet their methods and measures became commonplace in such research.

Methodological issues

Perhaps one of the attractions of research in institutional settings is that there appear to be quite fixed boundaries. But whilst the building may remain more or less stable, the residents, the staff and many other resources at their disposal change over time. Institutional settings also carry with them a history which may also have an affect on the lives of those who live and work in them. Yet despite this ability to change and adapt to new circumstances, much research into the quality of life of older people in institutional settings has been dominated by the cross-sectional survey, whereby a number of settings are examined at one point in time.²⁶

The use of the cross-sectional study has often been due to the nature of the research commission and research funding. However, some studies have attempted to build in a longitudinal element, albeit on a small scale. Tobin and Lieberman's important study in the USA interviewed older people both before and after admission to residential care.²⁷ In the UK, Booth's study *Home truths* incorporated an audit of resident characteristics,²⁸ and in the recent evaluation of the three experimental NHS nursing homes and other long-term care settings, the methodology has incorporated both a randomized controlled trial as well as a longitudinal study.²⁹ The value of being able to examine changes over time has been enormous.

Whether confined to one point in time, or over a longer period, research programmes will also invariably have to make crucial decisions over their main aims. As we have seen, the subject area is enormous. In the past, research has been specifically funded to look at particular aspects of quality of life, often within public sector settings. Few attempts have been made to measure all aspects of quality of life within residential settings through traditional research techniques,³⁰ although those carrying out small pieces of evaluative research based in one service or one geographic area may be able to obtain a

comprehensive view. The question then becomes: 'what data to collect and who from?'; 'how far is the research going to consider process as well as outcome?'; and 'what measures of outcome do we use?'.³²

A brief look at any of the research mentioned above will soon serve to identify the key dimensions of institutional life (Figure 1).

At the level of resources or inputs, the researcher wants to know about the costs involved, the building and its design, the characteristics of the staff and residents, the types of routines which operate, the activities which take place and the nature of the regime. Much of this material may be obtained through existing data, inspection of the physical environment and structured questionnaires to senior staff utilizing a range of tried-and-tested scales and schedules. Several publications offer both a review and critique of the measures most commonly used.^{31,32} Replication of methods has been encouraged in order to allow for compatibility over time, but there has also been an acknowledgement that such an approach may give us a one-sided view based predominantly on the views of the managers and experts.³³

So what about the process or experience of institutional life and the measurement of outcome? A number of authors have argued that process can be understood only through qualitative research methods. This usually involves some combination of in-depth interviews with residents, staff, and others who visit the setting on a less regular basis such as relatives and

other professionals coupled with observation of the setting over a sufficient period of time to cover both the daily/weekly routine. Different forms of observation have been developed from the straightforward participant observer³⁴ to the more exacting timed observation.³⁵

Such a multimethod approach to research is bound to have its difficulties, for it means acknowledging a wide range of group interests, unequal power relations and varied definitions of what constitutes successful service provision and quality. It has brought to light a number of issues of importance to researchers and those interested in bringing about change. These include the utility of satisfaction, well-being and survival as measures of outcome; how to develop methods to incorporate users' views and ensure that they are seen as representative and valid³⁶; problems of analysing data from a number of sources³⁷; and the intricacies of managing change.³⁸

Key findings

The research findings in this area have been well discussed elsewhere, and given the brevity of this article only the most influential findings are given here.²⁶ But first we should acknowledge two points: (1) that the evidence comes from a range of data – large-scale surveys and small, detailed studies, with studies of private sector facilities still being small in number; and (2) that given the individual and personal nature of quality of life our best attempt at understanding outcome is to consider 'what aspects of quality of life tend to be found together and what tend not to be'.²³

Research has highlighted both the complexity of institutional settings and the fact that there are different levels of institutional maturity; or, put another way, different levels of receptiveness to change within settings. Differences exist both within and between institutions.²⁸ For example, a poor physical environment may not be indicative of the quality of care, although it will obviously not enhance overall well-being amongst residents or staff job satisfaction. This finding also has a bearing on the relatively weak evidence given by residents in response to traditional measures of life satisfaction and psychological well-being, which often fail to differentiate between settings. However, findings do show that changes within

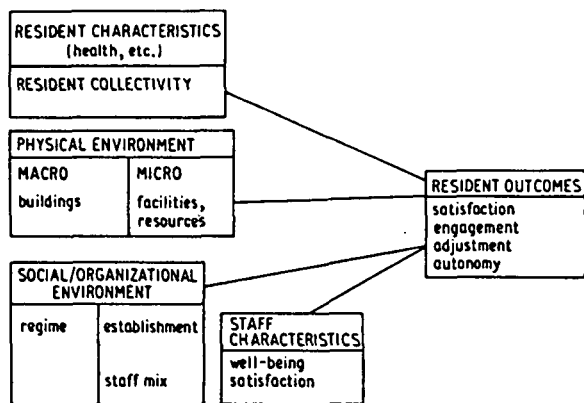


Figure 1 The model of the residential process (Reproduced with permission.¹⁶)

care settings such as the establishment of small group-living can have an impact.¹⁶

In terms of the social/organizational environment, the influence of the head of home or senior member of staff appears to be crucial both to the quality of care and the quality of life. This finding is reported by many researchers, often supported by qualitative data.²⁶ Within the private sector, where residential and nursing homes are smaller than those within the public and voluntary sectors, agreement between husband and wife (owners and managers) over the quality of care provided may be crucial.³⁹

While statistical evidence regarding the importance of factors such as the quality of physical care, staff/resident ratios, staff training, staff job satisfaction and staff attitudes in promoting resident well-being remains ambiguous, qualitative material indicates the importance of these aspects of staffing.⁴⁰ Staff in all sectors of residential and nursing home care are predominantly female and still largely untrained. However, staffing patterns in the private sector reveal greater reliance on part-time staff who take on both domestic and caring roles.³⁹

With regards to the characteristics of residents themselves, the importance of those predetermining factors which lead people to live in care settings must be recognized. These residents are survivors, most commonly widows in their eighties who have witnessed immense changes during their lives. The relocation process itself can be traumatic for some and changes in well-being and increased mortality rates are experiences following admission.⁴¹ Levels of mental and physical frailty amongst residents vary between settings, although researchers have also noted a degree of overlap. However, the morbidity profile of residents also changes over time, which can have important implications for the quality and practice of care.

Finally, in terms of the resident perspective on institutional life, there is evidence that certain aspects of life are important and valued. These include a level of environmental control which includes both the need for privacy and for an understanding of the way the organization is arranged in space; choice and self-determination with regard to aspects of daily routine; the relationships developed between residents and staff; and the value of links with the past and the

importance of visits.^{16,42} Work has also shown that the experience of living in long-term care may be qualitatively different for men and women.⁴³ We should stress, however, that these findings in many ways reflect the interests of funders, the interests of researchers and the questions asked. When the users set the questions the answers may be different.

Recent advances in quality control and quality assurance: issues for the future

There has clearly been a great deal of thinking about the evaluation of long-term care. In this article we have so far been concerned with the view of the academic researcher, the expert. But along with the changing fortunes of institutional settings for older people has come the idea that quality is something that needs to be assured as well as controlled.⁴⁴ These terms – quality assurance and quality control – derive from the worlds of business, management and economics, rather than from the sociopsychological disciplines which generated the paradigms used previously.

Quality control implies quality at a certain level and focuses attention most easily on objective measures; 'standards of living' within settings rather than the quality of life of the individual. The emphasis on 'value for money' in service provision has also led to the development of measures to enable managers and administrators to compare the benefits of a range of interventions (e.g. 'Total quality management',⁴⁵ British Standard B5750⁴⁶). In contrast, we could argue that systems of quality assurance have a more individual focus, which puts the complexity of life and the views of the user centre stage (e.g. 'Inside Quality Assurance'⁴⁷). The crucial dimension continues to be the separation or integration of care with individual life experiences, a dilemma which the QALY approach tries to overcome.⁴⁸ Whilst both sets of terms struggle with the validity of information about quality obtained either from an inside or from an outside perspective, there is a new element present: the requirement that the evaluation of quality care shall be made accountable to a concerned 'public' or community. The growing interest in auditing the quality of long-term care for older people is symptomatic of this development.⁴⁹

Up until the early/mid 1980s, it can be argued that quality of care and quality of life in institutional settings were considered by others on behalf of the recipient, who simply acted as a source of information. Changes in care practice came about as demand and economics required, or hot on the heels of scandal or disaster. The enactment of the Registered Homes Act in January 1984, which consolidated earlier legislation concerning the running of residential and nursing homes, coincided with a peak in the rapid expansion of private residential care which had begun in the early 1980s. These events, taken together, changed the shape of residential provision. The development of a regulatory mechanism was set in train so that statutory sector notions of good practice – culled from earlier research and policy-making – were brought into closer conjunction with private sector aspirations. At this point the role of the resident as consumer assumed a new dimension, although it is probably true to say that regulation was still an effort made on behalf of the individual user.⁵⁰

Inspection procedures, which lay at the centre of regulation, made more widespread and systematic evaluation necessary. Whilst there was considerable variation in the rate at which different local and health authorities built up and refined their regulatory practice, by the end of the 1980s the ideas of quality control and assurance were tentatively in place. Along with this, the idea that residents themselves could and should take an active part in assessing quality of care was endorsed first by the Wagner report³ and then in the white paper, *Caring for people*⁵¹ and the NHS and Community Care Act, 1990.⁵²

The active involvement of older people in these developments may result in 'quality of life' assuming some of the individual character that was being sought two or three decades ago, as sociopsychometric scaling attempted to express in collective terms the nature of personal well-being, morale and satisfaction within institutional life. As noted above, various schemes and systems have been, and are being, developed, particularly in relation to residential settings, which attempt to look at the collective world in more detail. There is a greater focus on the individual than can be managed through most, if not all, inspection systems. These developments have led to methodological innovations which open up the

research process to those who give and receive care. This means finding ways of overcoming the fears of those who still feel that the expert should be in control; developing methods which enable those with problems in communicating their views to have a voice; and, most of all, ensuring that such material is seen and used as a valid contribution to our knowledge about care settings.

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